Direct Renin Inhibitor & Combination Medications

NH Medicaid Prior Authorization Request Form

First Health Services Corporation
A Coventry Health Care Company

Fax: 1-888-603-7696 Phone: 1-866-675-7755

Date of Medication Request: ___ ___ /___ ___ /___ ___ ___ ___

Section I: Patient Information and Medication Requested:

Name: (Last, First) _____ NH Medicaid Number:___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name:_____ Strength:_____

Dosing Directions:_____ Length of Therapy:_____

Section II: Clinical History:

1. Is the medication being prescribed for the treatment of hypertension? ☐ Yes ☐ No
2. If no, please provide patient diagnosis for use of this medication: _____
3. Is the patient 18 years of age or older? ☐ Yes ☐ No
4. If female, is the patient pregnant? ☐ Yes ☐ No
5. Has the patient failed a trial or past therapy with an ACE Inhibitor or an ARB? ☐ Yes ☐ No

Please describe treatment failures and provide dates:

_____
_____
_____
_____
_____
_____

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet_____
_____
_____
_____
_____
_____
_____
_____

Section III: Prescriber Information:

Print Name:_____ NPI Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Signature of Prescribing Provider